P.O. Box 22999, Rochester, NY, 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Rochester Area Schools Health Plan 2 – Enrollment Form

PLEASE PRINT CLEARLY District Name: ____ Group #: ____

Section 1: Enrollment Information **Subgroup#:** ____

Member ID# ____

Type of Transaction **Please X**

☐ Add Subscriber ☐ *Add Dependent ☐ Remove Dependent ☐ Change of Coverage ☐ Change Gender

☐ Change Name (prev. name ____________) ☐ Transfer to COBRA/COBRA Effective Date:

Reason for Enrollment/Change

☐ New Hire ☐ Open Enrollment ☐ Loss of Coverage ☐ Retirement ☐ Divorce ☐ Other Coverage

☐ Work Status Change ____________

Add Dep. Reason: ☐ Marriage – Date:________ ☐ Newborn ☐ Court Order ☐ Domestic Partner

Choose Plan:

☐ Blue Point 2 Extended ☐ Blue Point 2 Select ☐ Blue Point 2 Value | ☐ Dental

Type of Coverage:

Medical: ☐ Single ☐ Family ☐ Subscriber & Spouse ☐ Subscriber & Child ☐ Family No Spouse

Dental: : ☐ Single ☐ Family ☐ Subscriber & Spouse ☐ Subscriber & Child ☐ Family No Spouse

Hire Date: ________ **Qualifying Event Date:** ________ **Effective Date:** ________

Subscriber Information

Last Name: ____________ **First Name:** ____________ **MI:** ____

Social Security #: ____ - ____ - ____ **Date of Birth:** / / **Gender:** **M** **F**

Mailing Address:

City: **State:** **Zip:**

Home Phone Number: **Other Phone:**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated**

Medicare # (if applicable) Part A Effective Date: Part B Effective Date:

Primary Care Physician Last Name: First Name:

OB/GYN Last Name: First Name:

Section 2: Dependent Information

Spouse/Domestic Partner Last Name: ____________ **First Name:** ____________

Social Security Number: ____ - ____ - ____ **Date of Birth:** / / **Gender:** **M** **F**

Primary Care Physician Last Name: First Name:

OB/GYN Last Name: First Name:

Dependent's Last Name: ____________ **First Name:** ____________

Social Security Number: ____ - ____ - ____ **Date of Birth:** / / **Gender:** **M** **F**

Primary Care Physician Last Name: First Name:

OB/GYN Last Name: First Name:

Dental Only: Full Time Student: Y N Expected Graduation Date:

Dependent's Last Name: ______________________ **First Name:** ______________

Social Security Number: _____ - _____ - _____ **Date of Birth:** ___/___/___ **Gender:** M F

Primary Care Physician Last Name: First Name:

OB/GYN Last Name: First Name:

Dental Only: Full Time Student: Y N Expected Graduation Date:

Dependent's Last Name: ______________________ **First Name:** ______________

Social Security Number: _____ - _____ - _____ **Date of Birth:** ___/___/___ **Gender:** M F

Primary Care Physician Last Name: First Name:

OB/GYN Last Name: First Name:

Dental Only: Full Time Student: Y N Expected Graduation Date:

Dependent's Last Name: ______________________ **First Name:** ______________

Social Security Number: _____ - _____ - _____ **Date of Birth:** ___/___/___ **Gender:** M F

Primary Care Physician Last Name: First Name:

OB/GYN Last Name: First Name:

Dental Only: Full Time Student: Y N Expected Graduation Date:

Section 3 Previous Coverage: If "Loss of Coverage" is selected, this section is REQUIRED.

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health? Y N Dental? Y N

If answering "Yes", are you keeping the additional health and/or dental coverage? Health? Y N Dental? Y N

Previous Insurance Carrier: Name of Policy Holder:

ID#: Effective Date: / / Termination Date: / /

Section 4 Release/Subscriber Signature Required. You must sign and date this form to be eligible for insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature: ______________________________ **Date:** ___/___/___

Section 5 Group Employer Information (This section should be completed by the Group Benefits Administrator. This application cannot Be processed without this information and a Signature.)

Medical Group #: 00044333 **Subgroup #:** **Class #:** **Dept. Code:**

Dental Group #: **Subgroup #:** **Pkg #:**

Group Administrator Signature: ______________________________ **Date:** ___/___/___

Subscriber Last Name: ______________________________

(08/2016)